Clinical Policy: Adalimumab (Humira), Adalimumab-afzb (Abrilada), Adalimumab-atto (Amjevita), Adalimumab-adbm (Cyltezo), Adalimumab-bwwd (Hadlima), Adalimumab-fkjp (Hulio), Adalimumab-adaz (Hyrimoz), Adalimumab-aacf (Idacio), Adalimumab-ryvk (Simlandi), Adalimumab-aaty (Yuflyma), Adalimumab-aqvh (Yusimry)

Reference Number: CP.PHAR.242
Effective Date: 08.16
Last Review Date: 08.24
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Adalimumab (Humira®), adalimumab-afzb (Abrilada™), adalimumab-atto (Amjevita™), adalimumab-adbm (Cyltezo®), adalimumab-bwwd (Hadlima™), adalimumab-fkjp (Hulio®), adalimumab-adaz (Hyrimoz®), adalimumab-aacf (Idacio®), adalimumab-ryvk (Simlandi®), adalimumab-aaty (Yuflyma®), and adalimumab-aqvh (Yusimry™) are tumor necrosis factor (TNF) blockers.

FDA Approved Indication(s)

Indications	Description	Humira	Abrilada, Amjevita, Cyltezo/adalimumab-adbm, Hadlima, Hulio/adalimumab-fkjp, Hyrimoz/adalimumab-adaz, Idacio, Simlandi, Yuflyma/adalimumab-aaty, Yusimry
Rheumatoid arthritis (RA)	Reducing signs and symptoms, inducing major clinical response, inhibiting the progression of structural damage, and improving physical function in adult patients with moderately to severely active RA	X	X
Juvenile idiopathic arthritis (JIA)	Reducing signs and symptoms of moderately to severely active polyarticular JIA in patients 2 years of age and older	X	X
Psoriatic arthritis (PsA)	Reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in adult patients with active PsA	X	X

Indications	Description	Humira	Abrilada, Amjevita, Cyltezo/adalimumab-adbm, Hadlima, Hulio/adalimumab-fkjp, Hyrimoz/adalimumab-adaz, Idacio, Simlandi, Yuflyma/adalimumab-aaty, Yusimry
Ankylosing spondylitis (AS)	Reducing signs and symptoms in adult patients with active AS	X	X
Crohn's disease (CD)	Treatment of moderately to severely active CD in adults and pediatric patients 6 years of age and older	X	X
Adult ulcerative colitis (UC)	Treatment of moderately to severely active ulcerative colitis in adult patients Limitation of use: Effectiveness has not been established in patients who have lost response to or were intolerant to TNF blockers	X	X
Pediatric UC	Treatment of moderately to severely active UC in pediatric patients 5 years of age and older Limitation of use: Effectiveness has not been established in patients who have lost response to or were intolerant to TNF blockers	X	–
Plaque psoriasis (PsO)	The treatment of adult patients with moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy, and when other systemic therapies are medically less appropriate	X	X
Pediatric hidradenitis suppurativa (HS)	The treatment of moderate to severe hidradenitis suppurativa in patients 12 years of age and older	X	–
Adult HS	The treatment of moderate to severe hiradenitis suppurativa in adult patients	X	X
Pediatric uveitis (UV)	The treatment of non-infectious intermediate, posterior and	X	–

Indications	Description	Humira	Abrilada, Amjevita, Cyltezo/adalimumab-adbm, Hadlima, Hulio/adalimumab-fkjp, Hyrimoz/adalimumab-adaz, Idacio, Simlandi, Yuflyma/adalimumab-aaty, Yusimry
	panuveitis in adults and pediatric patients 2 years of age and older		
Adult UV	The treatment of non-infectious intermediate, posterior, and panuveitis in adult patients	X	X

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Abrilada, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, adalimumab-fkjp, adalimumab-ryvk, Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Idacio, Simlandi, Yuflyma, and Yusimry are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Ankylosing Spondylitis (must meet all)**:**
1. Diagnosis of AS;
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 18 years;
4. If request is for Abrilada, Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or adalimumab-ryvk [NDC 82009-0156-22], member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Hadlima, Simlandi, Yusimry, adalimumab-aaty*, adalimumab-adaz*, adalimumab-adbm*, and adalimumab-fkjp*;
   See Appendix K for preferred NDCs
5. Failure of at least TWO NSAIDs at up to maximally indicated doses, each used for ≥ 4 weeks unless clinically significant adverse effects are experienced or all are contraindicated;
6. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
7. Dose does not exceed 40 mg every other week.

Approval duration: 6 months

B. Crohn's Disease (must meet all)**:**
1. Diagnosis of CD;
2. Prescribed by or in consultation with a gastroenterologist;

3. Age ≥ 6 years;
4. If request is for Abrilada, Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio,Yuflyma, or adalimumab-ryvk [NDC 82009-0156-22], member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Hadlima, Simlandi, Yusimry, adalimumab-aaty*, adalimumab-adaz*, adalimumab-adbm*, and adalimumab-fkjp*;
   See Appendix K for preferred NDCs
5. Member meets one of the following (a or b):
   a. Failure of a ≥ 3 consecutive month trial of at least ONE immunomodulator (e.g., azathioprine, 6-mercaptopurine [6-MP], MTX) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
   b. Medical justification supports inability to use immunomodulators (*see Appendix E*);
6. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
7. Dose does not exceed one of the following (a or b):
   a. Adults: 160 mg on Day 1 and 80 mg on Day 15, followed by maintenance dose of 40 mg every other week starting Day 29;
   b. Pediatrics (i or ii):
      i. Weight 17 kg (37 lbs.) to < 40 kg (88 lbs.): 80 mg on Day 1 and 40 mg on Day 15, followed by maintenance dose of 20 mg every other week starting Day 29;
      ii. Weight ≥ 40 kg (88 lbs): 160 mg on Day 1 and 80 mg on Day 15, followed by maintenance dose of 40 mg every other week starting Day 29.

Approval duration: 6 months

C. Hidradenitis Suppurativa (must meet all)**:**
1. Diagnosis of HS;
2. Prescribed by or in consultation with a dermatologist, rheumatologist, or gastroenterologist;
3. Member meets one of the following (a or b):
   a. For Humira: Age ≥ 12 years;
   b. For Abrilada, adalimumab-aaty, adalimumab-adaz, adalimumab-fkjp, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry: Age ≥ 18 years;
4. If member is ≥ 18 years and request is for Abrilada, Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or adalimumab-ryvk [NDC 82009-0156-22], member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Hadlima, Simlandi, Yusimry, adalimumab-aaty*, adalimumab-adaz*, adalimumab-adbm*, and adalimumab-fkjp*;
   See Appendix K for preferred NDCs
5. Documentation of Hurley stage II or stage III (*see Appendix D*);
6. Failure of a systemic antibiotic therapy (e.g., clindamycin, minocycline, doxycycline, rifampin) tried for ≥ 3 consecutive months, at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;

7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Dose does not exceed 160 mg on Day 1 and 80 mg on Day 15, followed by maintenance dose of 40 mg every week or 80 mg every other week starting Day 29.

Approval duration: 6 months

D. Plaque Psoriasis (must meet all)**:**

1. Diagnosis of moderate-to-severe PsO as evidenced by involvement of one of the following (a or b):
   a. ≥ 3% of total body surface area;
   b. Hands, feet, scalp, face, or genital area;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Age ≥ 18 years;
4. If request is for Abrilada, Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or adalimumab-ryvk [NDC 82009-0156-22], member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Hadlima, Simlandi, Yusimry, adalimumab-aaty*, adalimumab-adaz*, and adalimumab-adbm*, adalimumab-fkjp*;
   See Appendix K for preferred NDCs
5. Member meets one of the following (a, b, or c):
   a. Failure of a ≥ 3 consecutive month trial of MTX at up to maximally indicated doses;
   b. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a ≥ 3 consecutive month trial of cyclosporine or acitretin at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;
   c. Member has intolerance or contraindication to MTX, cyclosporine, and acitretin, and failure of phototherapy, unless contraindicated or clinically significant adverse effects are experienced;
6. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
7. Dose does not exceed 80 mg initial dose, followed by maintenance dose of 40 mg every other week starting one week after initial dose.

Approval duration: 6 months

E. Polyarticular Juvenile Idiopathic Arthritis (must meet all)**:**

1. Diagnosis of PJIA as evidenced by ≥ 5 joints with active arthritis;
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 2 years;
4. If request is for Abrilada, Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or adalimumab-ryvk [NDC 82009-0156-22], member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Hadlima, Simlandi, Yusimry, adalimumab-aaty*, adalimumab-adaz*, adalimumab-adbm*, and adalimumab-fkjp*;
   See Appendix K for preferred NDCs

5. Documented baseline 10-joint clinical juvenile arthritis disease activity score (cJADAS-10) (*see Appendix J*);
6. Member meets one of the following (a, b, c, or d):
   a. Failure of a ≥ 3 consecutive month trial of MTX at up to maximally indicated doses;
   b. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a ≥ 3 consecutive month trial of leflunomide or sulfasalazine at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated;
   c. For sacroiliitis/axial spine involvement (i.e., spine, hip), failure of a ≥ 4 week trial of an NSAID at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
   d. Documented presence of high disease activity as evidenced by a cJADAS-10 > 8.5 (*see Appendix J*);
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Dose does not exceed one of the following (a, b, or c):
   a. Weight 10 kg (22 lbs) to <15 kg (33 lbs): 10 mg every other week;
   b. Weight 15 kg (33 lbs) to < 30 kg (66 lbs): 20 mg every other week;
   c. Weight ≥ 30 kg (66 lbs): 40 mg every other week.

Approval duration: 6 months

F. Psoriatic Arthritis (must meet all)**:**
1. Diagnosis of PsA;
2. Prescribed by or in consultation with a dermatologist or rheumatologist;
3. Age ≥ 18 years;
4. If request is for Abrilada, Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or adalimumab-ryvk [NDC 82009-0156-22], member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Hadlima, Simlandi, Yusimry, adalimumab-aaty*, adalimumab-adaz*, adalimumab-adbm*, and adalimumab-fkjp*;
   See Appendix K for preferred NDCs
5. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
6. Dose does not exceed 40 mg every other week.

Approval duration: 6 months

G. Rheumatoid Arthritis (must meet all)**:**
1. Diagnosis of RA per American College of Rheumatology (ACR) criteria (*see Appendix G*);
2. Prescribed by or in consultation with a rheumatologist;
3. Age ≥ 18 years;
4. If request is for Abrilada, Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or adalimumab-ryvk [NDC 82009-0156-22], member must use ALL of the

following, unless clinically significant adverse effects are experienced or all are contraindicated: Hadlima, Simlandi, Yusimry, adalimumab-aaty*, adalimumab-adaz*, adalimumab-adbm*, and adalimumab-fkjp*;
See Appendix K for preferred NDCs

5. Member meets one of the following (a or b):
   a. Failure of a ≥ 3 consecutive month trial of MTX at up to maximally indicated doses;
   b. Member has intolerance or contraindication to MTX (*see Appendix D*), and failure of a ≥ 3 consecutive month trial of at least ONE conventional disease-modifying antirheumatic drug [DMARD] (e.g., sulfasalazine, leflunomide, hydroxychloroquine) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
6. Documentation of one of the following baseline assessment scores (a or b):
   a. Clinical disease activity index (CDAI) score (*see Appendix H*);
   b. Routine assessment of patient index data 3 (RAPID3) score (*see Appendix I)*;
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Dose does not exceed 40 mg every other week.

Approval duration: 6 months

H. Ulcerative Colitis (must meet all)**:**

1. Diagnosis of UC;
2. Prescribed by or in consultation with a gastroenterologist;
3. Member meets one of the following (a or b):
   a. For Humira: Age ≥ 5 years;
   b. For Abrilada, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, adalimumab-fkjp, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry: Age ≥ 18 years;
4. If member is ≥ 18 years and request is for Abrilada, Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or adalimumab-ryvk [NDC 82009-0156-22], member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Hadlima, Simlandi, Yusimry, adalimumab-aaty*, adalimumab-adaz*, adalimumab-adbm*, and adalimumab-fkjp*;
See Appendix K for preferred NDCs
5. Documentation of a Mayo Score ≥ 6 (*see Appendix F*);
6. Failure of an 8-week trial of systemic corticosteroids, unless contraindicated or clinically significant adverse effects are experienced;
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Dose does not exceed one of the following (a, b, or c):
   a. For adults: 160 mg on Day 1 and 80 mg on Day 15, followed by maintenance dose of 40 mg every other week starting Day 29;
   b. For Humira in pediatric patients weighing more than 20 kg, but less than 40 kg: 80 mg on Day 1, 40 mg on Day 8 and Day 15, followed by maintenance doses of 40 mg every other week or 20 mg every week;

c. For Humira in pediatric patients weighing more than 40 kg: 160 mg on Day 1 and 80 mg on Day 8 and 15, followed by maintenance doses of 80 mg every other week or 40 mg every week.

Approval duration: 6 months

I. Uveitis (must meet all)**:**

1. Diagnosis of non-infectious intermediate, posterior or panuveitis;
2. Prescribed by or in consultation with an ophthalmologist or rheumatologist;
3. Member meets one of the following (a or b):
   a. For Humira: Age ≥ 2 years;
   b. For Abrilada, adalimumab-aaty, adalimumab-adaz, adalimumab-adbm, adalimumab-fkjp, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry: Age ≥ 18 years;
4. If member is ≥ 18 years and request is for Abrilada, Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or adalimumab-ryvk [NDC 82009-0156-22], member must use all of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Hadlima, Simlandi, Yusimry, adalimumab-aaty*, adalimumab-adaz*, adalimumab-adbm*, and adalimumab-fkjp*;
   See Appendix K for preferred NDCs
5. Failure of a ≥ 2 week trial of a systemic corticosteroid (e.g., prednisone) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
6. Failure of a trial of a non-biologic immunosuppressive therapy (e.g., azathioprine, methotrexate, mycophenolate mofetil, cyclosporine, tacrolimus, cyclophosphamide, chlorambucil) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
7. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
8. Dose does not exceed 80 mg initial dose, followed by maintenance dose of 40 mg every other week starting one week after initial dose.

Approval duration: 6 months

J. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Rheumatoid Arthritis (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. If request is for Abrilada, Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or adalimumab-ryvk [NDC 82009-0156-22], member must use ALL of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Hadlima, Simlandi, Yusimry, adalimumab-aaty*, adalimumab-adaz*, and adalimumab-adbm*, adalimumab-fkjp*;
   See Appendix K for preferred NDCs
3. Member is responding positively to therapy as evidenced by one of the following (a or b):
   a. A decrease in CDAI (*see Appendix H*) or RAPID3 (*see Appendix I*) score from baseline;
   b. Medical justification stating inability to conduct CDAI re-assessment, and submission of RAPID3 score associated with disease severity that is similar to initial CDAI assessment or improved;
4. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
5. If request is for a dose increase, new dose does not exceed one of the following (a or b):*
   a. 40 mg every other week;
   b. Both of the following (i and ii):
      i. 40 mg every week (or 80 mg every other week);
      ii. Documentation supports inadequate response to a ≥ 3 month trial of 40 mg every other week or member is not a candidate for concurrent methotrexate and Humira due to contraindications or intolerance.

Approval duration: 12 months*

**(If new dosing regimen, approve for 6 months)*

B. All Other Indications in Section I (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*

2. Member meets one of the following (a, b, or c):
   a. For CD (both i and ii):
      i. Age ≥ 6 years;
      ii. If request is for Abrilada, Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or adalimumab-ryvk [NDC 82009-0156-22], member must use all of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Hadlima, Simlandi, Yusimry, adalimumab-aaty*, adalimumab-adaz*, adalimumab-adbm*, and adalimumab-fkjp*;
      See Appendix K for preferred NDCs
   b. For pJIA (both i and ii):
      i. Age ≥ 2 years;
      ii. If request is for Abrilada, Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or adalimumab-ryvk [NDC 82009-0156-22], member must use all of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Hadlima, Simlandi, Yusimry, adalimumab-aaty*, adalimumab-adaz*, adalimumab-adbm*, and adalimumab-fkjp*;
      See Appendix K for preferred NDCs
   c. For PsA, AS, UC, PsO, HS, UV: If member is ≥ 18 years and request is for Abrilada, Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or adalimumab-ryvk [NDC 82009-0156-22], member must use all of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Hadlima, Simlandi, Yusimry, adalimumab-aaty*, adalimumab-adaz*, adalimumab-adbm*, and adalimumab-fkjp*;
      See Appendix K for preferred NDCs
3. Member meets one of the following (a, b, or c):
   a. For HS, at least a 25% reduction in inflammatory nodules and abscesses;
   b. For pJIA, member is responding positively to therapy as evidenced by a decrease in cJADAS-10 from baseline (*see Appendix J*);
   c. For all other indications, member is responding positively to therapy;
4. Member does not have combination use with biological disease-modifying antirheumatic drugs or Janus kinase inhibitors (*see Section III: Diagnoses/Indications for which coverage is NOT authorized*);
5. If request is for a dose increase, new dose does not exceed one of the following (a, b, or c):
   a. PJIA, PsA, AS, CD, PsO, UV: 40 mg every other week;
   b. HS: 40 mg every week or 80 mg every other week;
   c. UC: one of the following (i or ii):
      i. 40 mg every other week or 20 mg every week;
      ii. 80 mg every other week or 40 mg every week, and member initiated Humira prior to 18 years of age.

Approval duration: 12 months*

**(If new dosing regimen, approve for 6 months)*

C. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents;

B. Combination use with biological disease-modifying antirheumatic drugs (bDMARDs) or potent immunosuppressants, including but not limited to any tumor necrosis factor (TNF) antagonists [e.g., Cimzia®, Enbrel®, Humira® and its biosimilars, Remicade® and its biosimilars (Avsola™, Inflectra™, Renflexis™, Zymfentra®), Simponi®], interleukin agents [e.g., Actemra® (IL-6RA), Arcalyst® (IL-1 blocker), Bimzelx® (IL-17A and F antagonist), Cosentyx® (IL-17A inhibitor), Ilaris® (IL-1 blocker), Ilumya™ (IL-23 inhibitor), Kevzara® (IL-6RA), Kineret® (IL-1RA), Omvoh™ (IL-23 antagonist), Siliq™ (IL-17RA), Skyrizi™ (IL-23 inhibitor), Stelara® (IL-12/23 inhibitor), Taltz® (IL-17A inhibitor), Tofidence™ (IL-6), Tremfya® (IL-23 inhibitor), Tyenne® (IL-6), Wezlana™ (IL-12/23 inhibitor)], Janus kinase inhibitors (JAKi) [e.g., Cibinqo™, Olumiant™, Rinvoq™, Xeljanz®/Xeljanz® XR,], anti-CD20 monoclonal antibodies [Rituxan® and its biosimilars (Riabni™, Ruxience™, Truxima®), Rituxan Hycela®], selective co-stimulation modulators [Orencia®], integrin receptor antagonists [Entyvio®], tyrosine kinase 2 inhibitors [Sotyktu™], and sphingosine 1-phosphate receptor modulator [Velsipity™] because of the additive immunosuppression, increased risk of neutropenia, as well as increased risk of serious infections.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

6-MP: 6-mercaptopurine
AS: ankylosing spondylitis
CD: Crohn's disease
CDAI: clinical disease activity index
cJADAS: clinical juvenile arthritis disease activity score
DMARD: disease-modifying antirheumatic drug
FDA: Food and Drug Administration
GI: gastrointestinal
HS: hidradenitis suppurativa
JAKi: Janus kinase inhibitors
MTX: methotrexate
NSAIDs: nonsteroidal anti-inflammatory drugs

PJIA: polyarticular juvenile idiopathic arthritis
PsA: psoriatic arthritis
PsO: psoriasis
RA: rheumatoid arthritis
RAPID3: routine assessment of patient index data 3
TNF: tumor necrosis factor
UC: ulcerative colitis
UV: uveitis

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
acitretin (Soriatane®)	**PsO** 25 or 50 mg PO QD	50 mg/day
azathioprine (Azasan®, Imuran®)	**RA** 1 mg/kg/day PO QD or divided BID **CD*,** 1.5 – 2 mg/kg/day PO **UV*** 2 - 3 mg/kg/day PO	2.5 mg/kg/day UV: 4 mg/kg/day
chlorambucil (Leukeran®)	**UV*** 0.2 mg/kg PO QD, then taper to 0.1 mg/kg PO QD or less	0.2 mg/kg/day
clindamycin (Cleocin®) + rifampin (Rifadin®)	**HS*** clindamycin 300 mg PO BID and rifampin 300 mg PO BID	clindamycin: 600 mg/day rifampin: 600 mg/day
corticosteroids	**CD*** *Adult:* prednisone 40 mg – 60 mg PO QD for 1 to 2 weeks, then taper daily dose by 5 mg weekly until 20 mg PO QD, and then continue with 2.5 – 5 mg decrements weekly or IV 50 – 100 mg Q6H for 1 week budesonide (Entocort EC®) 6 – 9 mg PO QD *Pediatric:* Prednisone 1 to 2 mg/kg/day PO QD	Various

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	UC* *Adult:* Prednisone 40 mg – 60 mg PO QD, then taper dose by 5 to 10 mg/week Budesonide (Uceris®) 9 mg PO QAM for up to 8 weeks *Pediatric:* Prednisone 1 to 2 mg/kg/day PO QD **UV*** *Adult:* prednisone 5 – 60 mg/day PO in 1 – 4 divided doses *Pediatric:* 0.14 to 2 mg/kg/day PO	
Cuprimine® (d-penicillamine)	**RA*** Initial dose: 125 or 250 mg PO QD Maintenance dose: 500 – 750 mg/day PO QD	1,500 mg/day
cyclophosphamide (Cytoxan®)	**UV*** 1 – 2 mg/kg/day PO	N/A
cyclosporine (Sandimmune®, Neoral®)	**PsO** 2.5 – 4 mg/kg/day PO divided BID **RA** 2.5 – 4 mg/kg/day PO divided BID **UV*** 2.5 – 5 mg/kg/day PO in divided doses	PsO, RA: 4 mg/kg/day UV: 5 mg/kg/day
doxycycline (Acticlate®)	**HS*** 50 – 100 mg PO BID	300 mg/day
hydroxychloroquine (Plaquenil®)	**RA*** Initial dose: 400 – 600 mg/day PO QD Maintenance dose: 200 – 400 mg/day PO QD	600 mg/day
leflunomide (Arava®)	**PJIA*** Weight < 20 kg: 10 mg every other day PO Weight 20 - 40 kg: 10 mg/day PO	20 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Weight > 40 kg: 20 mg/day PO **RA** Initial dose (for low risk hepatotoxicity or myelosuppression): 100 mg PO QD for 3 days Maintenance dose: 20 mg PO QD	
6-mercaptopurine (Purixan®)	**CD*** 50 mg PO QD or 0.75 – 1.5 mg/kg/day PO	1.5 mg/kg/day
methotrexate (Trexall®, Otrexup™, Rasuvo®, RediTrex®, Rheumatrex®, Jylamvo®)	**CD*** 15 – 25 mg/week IM or SC **PsO** 10 – 25 mg/week PO or 2.5 mg PO Q12 hr for 3 doses/week **PJIA*** 10 – 20 mg/m^2/week PO, SC, or IM **RA** 7.5 mg/week PO, SC, or IM or 2.5 mg PO Q12 hr for 3 doses/week **UV*** 7.5 – 20 mg/week PO	30 mg/week
minocycline (Minocin®)	**HS*** 50 – 100 mg PO BID	200 mg/day
mycophenolate mofetil (Cellcept®)	**UV*** 500 – 1,000 mg PO BID	3 g/day
NSAIDs (e.g., indomethacin, ibuprofen, naproxen, celecoxib)	**AS** Varies	Varies
Pentasa® (mesalamine)	**CD** 1,000 mg PO QID	4 g/day
Ridaura® (auranofin)	**RA** 6 mg PO QD or 3 mg PO BID	9 mg/day (3 mg TID)
sulfasalazine (Azulfidine®)	**PJIA*** 30-50 mg/kg/day PO divided BID	PJIA: 2 g/day RA: 3 g/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	RA Initial dose: 500 mg to 1,000 mg PO QD for the first week. Increase the daily dose by 500 mg each week up to a maintenance dose of 2 g/day. Maintenance dose: 2 g/day PO in divided doses	UC: 4 g/day
tacrolimus (Prograf®)	**CD*** 0.27 mg/kg/day PO in divided doses or 0.15 – 0.29 mg/kg/day PO **UV*** 0.1-0.15 mg/kg/day PO	N/A

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
**Off-label*

Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): none reported
- Boxed warning(s):
  - Serious infections
  - Malignancy

Appendix D: General Information
- Definition of failure of MTX or DMARDs
  - Child-bearing age is not considered a contraindication for use of MTX. Each drug has risks in pregnancy. An educated patient and family planning would allow use of MTX in patients who have no intention of immediate pregnancy.
  - Social use of alcohol is not considered a contraindication for use of MTX. MTX may only be contraindicated if patients choose to drink over 14 units of alcohol per week. However, excessive alcohol drinking can lead to worsening of the condition, so patients who are serious about clinical response to therapy should refrain from excessive alcohol consumption.
- Examples of positive response to therapy may include, but are not limited to:
  - Reduction in joint pain/swelling/tenderness
  - Improvement in ESR/CRP levels
  - Improvements in activities of daily living
- Hidradenitis suppurativa:
  - HS is sometimes referred to as: "acne inversa, acne conglobata, apocrine acne, apocrinitis, Fox-den disease, hidradenitis axillaris, HS, pyodermia sinifica fistulans, Velpeau's disease, and Verneuil's disease."

  - In HS, Hurley stages are used to determine severity of disease. Hurley stage II indicates moderate disease, and is characterized by recurrent abscesses, with sinus tracts and scarring, presenting as single or multiple widely separated lesions. Hurley stage III indicates severe disease, and is characterized by diffuse or near-diffuse involvement presenting as multiple interconnected tracts and abscesses across an entire area.
- Ulcerative colitis: there is insufficient evidence to support the off-label weekly dosing of adalimumab for the treatment of moderate-to-severe UC. It is the position of Centene Corporation® that the off-label weekly dosing of adalimumab for the treatment of moderate-to-severe UC is investigational and not medically necessary at this time.
  - The evidence from the *post hoc* study of the adalimumab pivotal trial suggests further studies are needed to confirm the benefit of weekly adalimumab dosing for the treatment of UC in patients with inadequate or loss of therapeutic response to treatment with adalimumab every other week. No large, randomized or prospective studies have been published to support the efficacy of the higher frequency of dosing, while national and international treatment guidelines also do not strongly support dose escalation of adalimumab for UC. The current market consensus is that weekly dosing of adalimumab is not medically necessary due to lack of evidence to support its benefit.

Appendix E: Immunomodulator Medical Justification

- The following may be considered for medical justification supporting inability to use an immunomodulator for Crohn's disease:
  - Inability to induce short-term symptomatic remission with a 3-month trial of systemic glucocorticoids
  - High-risk factors for intestinal complications may include:
    - Initial extensive ileal, ileocolonic, or proximal GI involvement
    - Initial extensive perianal/severe rectal disease
    - Fistulizing disease (e.g., perianal, enterocutaneous, and rectovaginal fistulas)
    - Deep ulcerations
    - Penetrating, stricturing or stenosis disease and/or phenotype
    - Intestinal obstruction or abscess
  - High risk factors for postoperative recurrence may include:
    - Less than 10 years duration between time of diagnosis and surgery
    - Disease location in the ileum and colon
    - Perianal fistula
    - Prior history of surgical resection
    - Use of corticosteroids prior to surgery

Appendix F: Mayo Score

- Mayo Score: evaluates ulcerative colitis stage, based on four parameters: stool frequency, rectal bleeding, endoscopic evaluation and Physician's global assessment. Each parameter of the score ranges from zero (normal or inactive disease) to 3 (severe activity) with an overall score of 12.

Score	Decoding
0 – 2	Remission

Score	Decoding
3 – 5	Mild activity
6 – 10	Moderate activity
>10	Severe activity

Appendix G: The 2010 ACR Classification Criteria for RA
Add score of categories A through D; a score of ≥ 6 out of 10 is needed for classification of a patient as having definite RA.

A	**Joint involvement**	Score
	1 large joint	0
	2-10 large joints	1
	1-3 small joints (with or without involvement of large joints)	2
	4-10 small joints (with or without involvement of large joints)	3
	> 10 joints (at least one small joint)	5
B	**Serology (at least one test result is needed for classification)**	
	Negative rheumatoid factor (RF) *and* negative anti-citrullinated protein antibody (ACPA)	0
	Low positive RF *or* low positive ACPA * *Low: < 3 x upper limit of normal*	2
	High positive RF *or* high positive ACPA * *High: ≥ 3 x upper limit of normal*	3
C	**Acute phase reactants (at least one test result is needed for classification)**	
	Normal C-reactive protein (CRP) and normal erythrocyte sedimentation rate (ESR)	0
	Abnormal CRP or abnormal ESR	1
D	**Duration of symptoms**	
	< 6 weeks	0
	≥ 6 weeks	1

Appendix H: Clinical Disease Activity Index (CDAI) Score
The Clinical Disease Activity Index (CDAI) is a composite index for assessing disease activity in RA. CDAI is based on the simple summation of the count of swollen/tender joint count of 28 joints along with patient and physician global assessment on VAS (0–10 cm) Scale for estimating disease activity. The CDAI score ranges from 0 to 76.

CDAI Score	Disease state interpretation
≤ 2.8	Remission
> 2.8 to ≤ 10	Low disease activity
> 10 to ≤ 22	Moderate disease activity
> 22	High disease activity

Appendix I: Routine Assessment of Patient Index Data 3 (RAPID3) Score
The Routine Assessment of Patient Index Data 3 (RAPID3) is a pooled index of the three patient-reported ACR core data set measures: function, pain, and patient global estimate of status. Each of the individual measures is scored 0 – 10, and the maximum achievable score is 30.

RAPID3 Score	Disease state interpretation
≤ 3	Remission
3.1 to 6	Low disease activity
6.1 to 12	Moderate disease activity
> 12	High disease activity

Appendix J: Clinical Juvenile Arthritis Disease Activity Score based on 10 joints (cJADAS-10)

The cJADAS10 is a continuous disease activity score specific to JIA and consisting of the following three parameters totaling a maximum of 30 points:

- Physician's global assessment of disease activity measured on a 0-10 visual analog scale (VAS), where 0 = no activity and 10 = maximum activity;
- Parent global assessment of well-being measured on a 0-10 VAS, where 0 = very well and 10 = very poor;
- Count of joints with active disease to a maximum count of 10 active joints*

**ACR definition of active joint: presence of swelling (not due to currently inactive synovitis or to bony enlargement) or, if swelling is not present, limitation of motion accompanied by pain, tenderness, or both*

cJADAS-10	Disease state interpretation
≤ 1	Inactive disease
1.1 to 2.5	Low disease activity
2.51 to 8.5	Moderate disease activity
> 8.5	High disease activity

Appendix K: Preferred Adalimumab Biosimilar NDCs

GPI Name	Brand Names	Strength	NDC
Adalimumab-aaty Auto-injector 1-Pen Kit	Unbranded	40 mg/0.4 mL	72606-0022-09
Adalimumab-aaty Auto-injector 2-Pen Kit	Unbranded	40 mg/0.4 mL	72606-0022-10
Adalimumab-aaty Auto-injector 1-Pen Kit	Unbranded	80 mg/0.8 mL	72606-0040-04
Adalimumab-aaty Prefilled Syringe Kit	Unbranded	20 mg/0.2 mL	72606-0041-01
Adalimumab-aaty Prefilled Syringe Kit	Unbranded	40 mg/0.4 mL	72606-0022-06
Adalimumab-adaz Soln Auto-injector	Unbranded	40 mg/0.4 mL	61314-0327-20
Adalimumab-adaz Soln Auto-injector	Unbranded	40 mg/0.4 mL	61314-0327-96
Adalimumab-adaz Soln Prefilled Syringe	Unbranded	40 mg/0.4 mL	61314-0327-64
Adalimumab-adaz Soln Prefilled Syringe	Unbranded	40 mg/0.4 mL	61314-0327-94
Adalimumab-fkjp Auto-injector Kit	Unbranded	40 mg/0.8 mL	49502-0416-02

GPI Name	Brand Names	Strength	NDC
Adalimumab-fkjp Auto-injector Kit	Unbranded	40 mg/0.8 mL	49502-0416-06
Adalimumab-fkjp Prefilled Syringe Kit	Unbranded	20 mg/0.4 mL	49502-0417-02
Adalimumab-fkjp Prefilled Syringe Kit	Unbranded	20 mg/0.4 mL	49502-0417-06
Adalimumab-fkjp Prefilled Syringe Kit	Unbranded	40 mg/0.8 mL	49502-0418-02
Adalimumab-fkjp Prefilled Syringe Kit	Unbranded	40 mg/0.8 mL	49502-0418-06
Adalimumab-aqvh Soln Pen-injector	Yusimry	40 mg/0.8 mL	70114-0220-02
Adalimumab-bwwd Soln Auto-injector	Hadlima (Pushtouch)	40 mg/0.4 mL	78206-0187-01
Adalimumab-bwwd Soln Auto-injector	Hadlima (Pushtouch)	40 mg/0.8 mL	78206-0184-01
Adalimumab-bwwd Soln Prefilled Syringe	Hadlima	40 mg/0.4 mL	78206-0186-01
Adalimumab-bwwd Soln Prefilled Syringe	Hadlima	40 mg/0.8 mL	78206-0183-01
Adalimumab-adbm Auto-injector Kit	Unbranded	40 mg/0.8 mL	0597-0545-22
Adalimumab-adbm Prefilled Syringe Kit	Unbranded	10 mg/0.2 mL	0597-0585-89
Adalimumab-adbm Prefilled Syringe Kit	Unbranded	20 mg/0.4 mL	0597-0555-80
Adalimumab-adbm Prefilled Syringe Kit	Unbranded	40 mg/0.4 mL	0597-0565-20
Adalimumab-adbm Auto-injector Kit	Unbranded	40 mg/0.4 mL	0597-0575-50
Adalimumab-adbm Auto-injector Crohns/UC/HS Starter Kit	Unbranded	40 mg/0.4 mL	0597-0575-60
Adalimumab-adbm Auto-injector Psoriasis/Uveitis Starter Kit	Unbranded	40 mg/0.4 mL	0597-0575-40
Adalimumab-adbm Prefilled Syringe Kit	Unbranded	40 mg/0.8 mL	0597-0595-20
Adalimumab-adbm Auto-injector Crohns/UC/HS Starter Kit	Unbranded	40 mg/0.8 mL	0597-0545-66

GPI Name	Brand Names	Strength	NDC
Adalimumab-adbm Auto-injector Psoriasis/Uveitis Starter Kit	Unbranded	40 mg/0.8 mL	0597-0545-44
Adalimumab-ryvk Auto-injector Kit	Simlandi (1-Pen Kit)	40 mg/0.4 mL	51759-0402-17
Adalimumab-ryvk Auto-injector Kit	Simlandi (2-Pen Kit)	40 mg/0.4 mL	51759-0402-02

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Adalimumab and biosimilars (Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry)	RA	40 mg SC every other week Some patients with RA not receiving concomitant methotrexate may benefit from increasing the frequency to 40 mg every week or 80 mg every other week.	40 mg/week
	PJIA	**Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hyrimoz, Idacio:** Weight 10 kg (22 lbs) to < 15 kg (33 lbs): 10 mg SC every other week **Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Idacio, Yuflyma:** Weight 15 kg (33 lbs) to < 30 kg (66 lbs): 20 mg SC every other week **Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry:** Weight ≥ 30 kg (66 lbs): 40 mg SC every other week	40 mg every other week
	PsA AS	40 mg SC every other week	40 mg every other week
	CD	Initial dose: *Adults:* 160 mg SC on Day 1, then 80 mg SC on Day 15 *Pediatrics:* **Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Idacio, Yuflyma:** Weight 17 kg (37 lbs) to < 40 kg (88 lbs): 80 mg SC on Day 1, then 40 mg SC on Day 15	40 mg every other week

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry: Weight ≥ 40 kg (88 lbs): 160 mg SC on Day 1, then 80 mg SC on Day 15 Maintenance dose: *Adults:* 40 mg SC every other week starting on Day 29 *Pediatrics:* **Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Idacio, Yuflyma:** Weight 17 kg (37 lbs) to < 40 kg (88 lbs): 20 mg SC every other week starting on Day 29 **Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry:** Weight ≥ 40 kg (88 lbs): 40 mg SC every other week starting on Day 29	
	UC	Initial dose: *Adults:* 160 mg SC on Day 1, then 80 mg SC on Day 15 Maintenance dose: *Adults:* 40 mg SC every other week starting on Day 29	40 mg every week
	PsO	Initial dose: 80 mg SC Maintenance dose: 40 mg SC every other week starting one week after initial dose	40 mg every other week
	HS	**Humira:** *For patients 12 years of age and older weighing at least 30 kg:* Initial dose: Weight 30 kg (66 lbs) to < 60 kg (132 lbs): 80 mg SC on Day 1, then 40 mg on Day 8 Weight ≥ 60 kg (132 lbs): 160 mg SC on Day 1, then 80 mg SC on Day 15	40 mg/week

Drug Name	Indication	Dosing Regimen	Maximum Dose
		Maintenance dose: Weight 30 kg (66 lbs) to < 60 kg (132 lbs): 40 mg every other week Weight ≥ 60 kg (132 lbs): 40 mg SC every week or 80 mg SC every other week starting on Day 29 **Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry:** Initial dose: *Adults:* 160 mg SC on day 1, then 80 mg SC on Day 15 Maintenance dose: *Adults:* 40 mg SC every week or 80 mg SC every other week starting on Day 29	
	UV	**Humira:** *Pediatrics:* Weight 10 kg (22 lbs) to < 15 kg (33 lbs): 10 mg SC every other week Weight 15 kg (33 lbs) to < 30 kg (66 lbs): 20 mg SC every other week Weight ≥ 30 kg (66 lbs): 40 mg SC every other week **Humira, Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi, Yuflyma, Yusimry:** *Adults:* Initial dose of 80 mg SC, followed by 40 mg SC every other week starting one week after the initial dose	40 mg every other week

Drug Name	Indication	Dosing Regimen	Maximum Dose
Adalimumab (Humira)	Pediatric UC	Initial dose: *Pediatrics:* **Weight** / **Days 1 through 15** 20 kg to less than 40 kg: Day 1: 80 mg; Day 8: 40 mg; Day 15: 40 mg 40 kg and greater: Day 1: 160 mg (single dose or split over two consecutive days); Day 8: 80 mg; Day 15: 80 mg *Pediatrics:* **Weight** / **Starting on Day 29*** 20 kg to less than 40 kg: 40 mg every other week or 20 mg every week 40 kg and greater: 80 mg every other week or 40 mg every week **Continue the recommended pediatric dosage in patients who turn 18 years of age and who are well-controlled on Humira regimen.*	80 mg every other week or 40 mg every week

VI. Product Availability

Drug Name	Availability
Adalimumab (Humira)	• Single-dose prefilled pen: 80 mg/0.8 mL, 40 mg/0.8 mL, 40 mg/0.4 mL • Single-dose prefilled syringe: 80 mg/0.8 mL, 40 mg/0.8 mL, 40 mg/0.4 mL, 20 mg/0.4 mL, 20 mg/0.2 mL, 10 mg/0.2 mL, 10 mg/0.1 mL • Single-use vial for institutional use only: 40 mg/0.8 mL
Adalimumab-afzb (Abrilada)	• Single-dose prefilled pen (Abrilada Pen): 40 mg/0.8 mL • Single dose prefilled syringe: 40 mg/0.8 mL, 20 mg/0.4 mL, 10 mg/0.2 mL • Single-dose glass vial for institutional use only: 40 mg/0.8 mL
Adalimumab-atto (Amjevita)	• Single-dose prefilled SureClick autoinjector: 80 mg/0.8 mL, 40 mg/0.8 mL, 40 mg/0.4 mL • Single-dose prefilled syringe: 80 mg/0.8 mL, 40 mg/0.8 mL, 40 mg/0.4 mL, 20 mg/0.4 mL, 20 mg/0.2 mL, 10 mg/0.2 mL
Adalimumab-adbm (Cyltezo)	• Single-dose prefilled syringe: 40 mg/0.4 mL, 40 mg/0.8 mL, 20 mg/0.4 mL, 10 mg/0.2 mL • Single-dose prefilled pen (Cyltezo Pen): 40 mg/0.4 mL, 40 mg/0.8 mL

Drug Name	Availability
Adalimumab-bwwd (Hadlima)	• Single-dose prefilled autoinjector (Hadlima PushTouch): 40 mg/0.8 mL, 40 mg/0.4 mL (citrate-free) • Single-dose prefilled syringe: 40 mg/0.8 mL, 40 mg/0.4 mL (citrate-free) • Single-dose glass vial for institutional use only: 40 mg/0.8 mL
Adalimumab-fkjp (Hulio)	• Single-dose prefilled pen (Hulio Pen): 40 mg/0.8 mL • Single-dose prefilled syringe: 40 mg/0.8 mL, 20 mg/0.4 mL
Adalimumab-adaz (Hyrimoz)	• Single-dose prefilled glass syringe (with BD UltraSafe Passive™ Needle Guard): 20 mg/0.4 mL, 40 mg/0.8 mL, 40 mg/0.4 mL, 80 mg/0.8 mL • Single-dose prefilled pen (Sensoready® Pen): 40 mg/0.8 mL, 40 mg/0.4 mL, 80 mg/0.8 mL • Single-dose prefilled glass syringe: 10 mg/0.2 mL, 10 mg/0.1 mL, 20 mg/0.2 mL
Adalimumab-aacf (Idacio)	• Single-dose prefilled pen (Idacio Pen): 40 mg/0.8 mL • Single-dose prefilled glass syringe: 40 mg/0.8 mL • Single-dose institutional use vial kit: 40 mg/0.8 mL
Adalimumab-ryvk (Simlandi)	• Single-dose autoinjector: 40 mg/0.4 mL
Adalimumab-aaty (Yuflyma)	• Single-dose prefilled auto-injector (Yuflyma AI): 40 mg/0.4 mL, 80 mg/0.8 mL • Single-dose prefilled syringe with safety guard: 40 mg/0.4 mL, 80 mg/0.8 mL • Single-dose prefilled syringe: 20 mg/0.2 mL, 40 mg/0.4 mL, 80 mg/0.8 mL
Adalimumab-aqvh (Yusimry)	• Single-dose prefilled pen (Yusimry Pen): 40 mg/0.8 mL • Single-dose prefilled glass syringe: 40 mg/0.8 mL

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Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J0135	Injection, adalimumab, 20 mg
Q5131	Injection, adalimumab-aacf (idacio), biosimilar, 20 mg
Q5132	Injection, adalimumab-afzb (abrilada), biosimilar, 10 mg
C9399	Unclassified drugs or biologicals
J3590	Unclassified biologics

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2020 annual review: added Hyrimoz to the policy; for UC, revised redirection from AZA, 6-MP, and ASA to corticosteroids and added requirement of Mayoscore of at least 6; for RA, added specific diagnostic criteria for definite RA, baseline CDAI score requirement, and decrease in CDAI score as positive response to therapy; for HS, revised requirement from systemic antibiotics to additionally require oral retinoids or hormonal therapy, and required at least a 25% reduction in inflammatory nodules and abscesses for reauthorization; references reviewed and updated.	04.23.20	05.20
Revised typo in Appendix E from “normal ESR” to “abnormal ESR” for a point gained for ACR Classification Criteria.	11.22.20	
Updated pJIA criteria to require diagnosis as evidenced by ≥ 5 joints, cJADAS assessment, and redirection to Enbrel and Xeljanz per SDC.	11.24.20	02.21

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Additionally, updated criteria to allow tiered redirection or bypass of MTX in the event of sacroiliitis or high disease activity. Added criteria for RAPID3 assessment for RA given limited in-person visits during COVID-19 pandemic, updated appendices.		
2Q 2021 annual review: added additional criteria related to diagnosis of moderate-to-severe PsO per 2019 AAD/NPF guidelines specifying at least 3% BSA involvement or involvement of areas that severely impact daily function; added combination of bDMARDs under Section III; updated CDAI table with ">" to prevent overlap in classification of severity; clarified that different therapeutic classes must be tried for HS, each for 3 months; references reviewed and updated. RT4: updated criteria to reflect pediatric extension for UC to include patients 5 years of age and older.	05.04.21	05.21
Per August SDC and prior clinical guidance, for RA added Actemra to redirect options and modified to require a trial of all; For PsA removed Simponi as a redirect option and modified to require a trial of all; for AS modified from trial of two to trial of all; for Xeljanz redirection requirements added bypass for members with cardiovascular risk and qualified redirection to apply only for member that has not responded or is intolerant to one or more TNF blockers; added Legacy WellCare line of business to policy (WCG.CP.PHAR.242 to be retired).	08.25.21	11.21
RT4: updated FDA approved indications to reflect pediatric extensions for Cyltezo in JIA and CD.	11.01.21	
2Q 2022 annual review: for PJIA, added redirection to Actemra per February SDC; for RA, added redirection to Olumiant per February SDC; for AS, added redirection to Xeljanx if failed prior TNF blocker per August SDC and updated FDA labeling; for PsO, allowed phototherapy as alternative to systemic conventional DMARD if contraindicated or clinically significant adverse effects are experienced; removed separate legacy Wellcare approval durations; reiterated requirement against combination use with a bDMARD or JAKi from Section III to Sections I and II; references reviewed and updated.	02.18.22	05.22
RT4: added biosimilars Abrilada and Hulio to policy; added new dosage form (single-dose glass vial) for Hadlima; updated FDA approved indications to reflect pediatric extensions for JIA and CD indications for Abrilada, Amjevita, Hadlima, Hulio, and Hyrimoz; added limitations of use for UC per PI.	08.09.22	
RT4: added new dosage form (citrate-free 40 mg/0.4 mL PushTouch and prefilled syringe) for Hadlima. Template changes applied to other diagnoses/indications and continued therapy section.	09.07.22	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Per November SDC, removed step therapy requiring redirection to branded biologics for all indications in initial and continued therapy section; for HS, removed redirection to oral retinoids and hormonal treatment.	11.18.22	
Per February SDC, for Amjevita added criteria requiring use of preferred NDCs along with reference to Appendix K; for UV, HS, and pediatric UC, criteria updated to allow Humira use only; RT4: added biosimilar Idacio to policy.	02.13.23	
2Q 2023 annual review: no significant changes; references reviewed and updated. RT4: added Yusimry biosimilar and new dosage form (prefilled auto-injector pen) to policy; updated biosimilar dosing in section V; added Hyrimoz high-concentration dosage forms to policy; for Amjevita, Cyltezo, Hyrimoz, and Yusimry, updated FDA approved indications to reflect new HS indication and added Amjevita to HS criteria; updated biosimilar dosing in section V; for Amjevita, added 10 mg/0.2 mL prefilled glass syringe dosage form.	04.18.23	05.23
RT4: for Cyltezo, added new dosage form (single-dose prefilled pen 40 mg/0.8 mL) and single-dose prefilled syringe 10 mg/0.2 mL to policy; RT4: added Yuflyma biosimilar to policy. Added HCPCS codes [Q5131] and [C9399].	05.31.23	
RT4: for Abrilada, updated FDA approved indications and dosing in section V to reflect new HS indication; for HS and UC, added respective biosimilars to criteria based on approved indication.	06.21.23	
Per July SDC: added criteria requiring use of preferred Humira biosimilars Yusimry, Hadlima, unbranded adalimumab-fkjp, and unbranded adalimumab-adaz to policy; added Appendix K for preferred adalimumab product NDC reference; removed criteria requiring use of preferred Amjevita NDCs and Appendix with Amjevita NDC references. RT4: for Amjevita, Cyltezo, Hadlima, updated FDA approved indications, approval criteria, and dosing in section V to reflect new UV indication; for Hadlima and Hulio, updated FDA approved indications, approval criteria, and dosing in section V to reflect new HS indication.	07.25.23	
RT4: for Amjevita, added new strengths for prefilled autoinjector 40 mg/0.4 mL, 80 mg/0.8 mL and prefilled syringe 20 mg/0.2 mL, 40 mg/0.4 mL, 80 mg/0.8 mL in section VI; for Abrilada, Hulio/ adalimumab-fkjp, Hyrimoz/ adalimumab-adaz, and Yusimry, updated FDA approved indications, approval criteria, and dosing in section V to reflect new UV indication; for continued therapy, updated criteria from “member must use one of the following” preferred biosimilars to “member must use all of the following” preferred biosimilars; for Yuflyma, added new strengths for auto-injector 80 mg/0.8 mL,	09.19.23	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
prefilled syringe with safety guard 80 mg/0.8 mL, and prefilled syring 20 mg/0.2 mL and 08 mg/0.8 mL and updated Yuflyma pediatric weight base dosing for pJIA and CD in section V; for Idacio, updated FDA approved indications, approval criteria, and dosing in section V to reflect new HS indication; added Tofidence to section III.B. Added HCPCS code [Q5132].		
Per December SDC, added unbranded adalimumab-adbm with specific NDCs to Appendix K to list of preferred adalimumab products. RT4: for Idacio, added newly approved UV indication to criteria; added Wezlana to section III.B; RT4: for Idacio, added new dosage formulation [single-dose institutional use vial kit: 40 mg/0.8 mL]; for CD and pJIA, updated pediatric dosing in section V.	12.06.23	02.24
2Q 2024 annual review: RT4: for Yuflyma, added newly approved UV indication to criteria; added HCPCS codes [C9399] and [J3590]; added Bimzelx, Zymfentra, Omvoh, Sotyktu, and Velsipity to section III.B; references reviewed and updated. RT4: added newly approved biosimilar Simlandi to criteria.	03.25.24	05.24
RT4: for Cyltezo, added new 40 mg/0.4 mL dosage strengths for single-dose pen and single-dose prefilled syringe. Added unbranded adalimumab-adbm 40 mg/0.4 mL specific NDCs [0597-0575-40, 0597-0575-50, 0597-0575-60, 0597-0565-20] to Appendix K to list of preferred adalimumab products.	05.13.24	
Per June SDC: added Simlandi with specific NDCs [51759-0402-17 and 51759-0402-02] to Appendix K to list of preferred adalimumab products; added adalimumab-ryvk [NDC 82009-0156-22] to list of requested products where redirection would apply. Per SDC: added adalimumab-aaty (unbranded Yuflyma) with specific NDCs [72606-0022-09, 72606-0022-10, 72606-0040-04, 72606-0041-01, 72606-0022-06] to Appendix K and to list of preferred adalimumab products.	07.23.24	08.24

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health

plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.